The creation of standards for nursing homes and the care given in them has become an important facet of community health. The development and adoption of standards for proprietary nursing homes in New York City was a pioneer advance and is presented here, indicating how government can insist on and implement high standards. This is now a national problem, and the New York experience should be examined in this context.

PROPRIETARY NURSING HOME STANDARDS IN NEW YORK CITY

Ray E. Trussell, M.D., M.P.H., F.A.P.H.A.

PROPRIETARY nursing homes account for more than 85 per cent of the available nursing-home beds in the nation. In New York City currently there are 87 such nursing homes licensed to operate 8,900 beds. Of these beds, approximately 6,000 are occupied by patients paid for by government. Thus, government as a third party purchaser of nursing home care has a big investment—financially and morally—in what goes on in such facilities. Furthermore, in New York City local government, acting through the Department of Hospitals, is legally responsible for the standards of care in proprietary nursing homes.

Third party purchasers of health care services have both an opportunity and an obligation to constantly strive for higher standards. However, it is safe to say that a substantial number of people do not have readily available to them the "latest" and "best" which is all the more reason to make the most of every opportunity to narrow the gap.

Government is emerging in this country as a very important third party in the provision of health care. Government is charged at every level with varying degrees of explicitly stated legal responsibility for protection of health and welfare. It follows simply and clearly that government must concern itself with standards even more than other third party sources of payment for patient care, which often are limited in what they can or are willing to do. They do not have legal mandates, although the social and moral issues are before them. Government, particularly state and local government, has the legal mandate as well. The powers of the federal government have been restricted, in part, under the new Medicare legislation—perhaps too much so for hospitals but not for nursing homes which wish to qualify as "extended care facilities."*

If a simple working definition of "quality" is accepted as that level of care which at any one time professional leaders say is desirable, two unavoid-

* Portions of this paper are excerpted from the author's remarks at the 1965 White House Conference on Health.

able conditions are immediately established for protection of the public: (1) a working partnership between the professions and government, and (2) periodic reappraisal and upgrading of standards. In this connection, reliable utilization and inspection data of several kinds are very helpful.

Much has happened and is happening in this country to improve the quality of health services. Government, as a third party with legal responsibilities for the protection of health, must constantly encourage these developments by continued investment and cooperation. And, even as important, government and other third parties must not discourage them by underpricing the services it purchases. There is reason for deep concern that false economies or unwise long-range policies about what will be paid for may have adverse effects which might not become evident for several years. Third parties that want the best, now and for the future, must be prepared to pay for it while simultaneously demanding the right to be sure that they are purchasing what they are promised.

Conversely, the providers of service must meet government half way by refusing to condone poor service. Yet, the record on both sides nationally is not too good. Just because it is possible to point with pride to the millions who receive care under circumstances which the professions seek even for themselves and their families does not justify ignoring evidence of poor care, using the argument that 20 years from now things will also be better for "those" people.

Uniform Standards

Uniform standards of care cannot be expected nationally because of the vast regional differences in resources, development, and leadership. Fortunately, the Medicare legislation requires the secretary of health, education, and welfare to observe standards adopted by states and local political subdivisions thereof which are higher than federal standards. This provision places the ultimate responsibility for protection of patients squarely in the hands and hearts of local communities and states as a matter of federal policy. Each is free to move ahead as resources permit.

In New York City, as a consequence of a medical audit of the care of public assistance patients in proprietary nursing homes, reports from inspectors of the Department of Hospitals, reports from other city agencies, and occasional newspaper stories, it was decided in 1961 that the code governing the licensure and supervision of such facilities should be updated. The City Charter authorizes the Board of Hospitals to promulgate standards applicable to those institutions licensed by the commissioner of hospitals. Only the board can adopt standards and only the board can grant exceptions. Notwithstanding any other provision of the law this code can be established and has the effect of law. In 1965 the State Legislature affirmed this long-standing local charter provision as a part of a sweeping legislative action affecting hospitals and nursing homes statewide (Public Law 795). The basic authority of the board also has been tested in court on several occasions and so far has always been upheld.

In the process of code revision a prolonged and thorough process of consultation, committee work, and staff work went on for more than a year. Dr. Jacob Horowitz served as coordinator of all these activities on loan as a part-time consultant from the Health Department.* The New York City Heart Association assisted in meeting necessary expenses through a grant of

* Dr. Horowitz is now assistant commissioner for charitable and proprietary institutions, Department of Hospitals.

$10,000 which was administered by the Greater New York Hospital Association.

A committee of approximately 80 persons, representing local and state agencies, voluntary institutions and agencies, proprietary nursing home owners and their legal counsels, individuals with special knowledge and experience, and university faculty members, was asked to assist the Department of Hospitals in working through the code revision. In between full committee meetings a subcommittee worked on draft revisions and many individual meetings were held with special groups or agencies such as architects or the Fire Department. The full committee met three times, the working subcommittee six times. The draft code went through at least eight major rewrites and countless minor changes.

The proprietary nursing home representatives, especially when involved in detailed drafting as members of the working subcommittee, were variously helpful, suspicious, openly hostile or downright obstructionist. Claims were made that the department was trying to kill the industry, that future construction standards (largely Hill-Burton) were too high and that no new nursing homes would be built in New York City (an allegation proved false by subsequent events).

The proposed code was then subjected to a public hearing under the auspices of the Code Committee of the Board of Hospitals. It received strong endorsement by a very large number of witnesses, although the hearing was boycotted by representatives of the proprietary nursing home industry, which was not only divided into several camps but was still trying to block the revisions.

Finally, the proposed code revision was presented to the full Board of Hospitals by its code subcommittee with the request that all members study it carefully for one month and be prepared for appropriate action at their next regular meeting.

When the next meeting of the Board of Hospitals was convened a special delegation from the proprietary nursing home field demanded a brief audience and this was granted. This group made three demands:

1. Make the new code applicable only to future nursing homes, or
2. Give a blanket "grandfather clause" exemption forthwith to all existing homes, or
3. Start over.

The board dealt firmly with this matter and having considered the new code carefully, adopted it, and authorized its publication in the City Record for three days, after which it has had the force of law.

Space limitations here allow only for highlights of the code provisions, but the reader should keep in mind that the document is far more inclusive. Only the introductory sentences to each section are quoted. In view of the current emphasis on standards of care the examples given are related to patient care and rights. The construction standards adopted were essentially those of the Hill-Burton program.*

"STAFF ORGANIZATION AND QUALIFICATIONS

"3.03. Licensee

"The Licensee shall be responsible for the care and safety of the patients, the provision and maintenance of the physical plant and equipment, the personnel policies and practices and the business management.

"3.04. Administrative Officer

"Each home shall be under the supervision of a qualified administrative officer. The administrator shall be an individual who is in good health; of good moral character; shall have suc-

* The entire code can be secured from the City Record, Municipal Building, New York 7, N. Y., for 55 cents.

cessfully completed a high school education or its educational equivalent; and shall have successfully completed courses in hospital administration, nursing home administration, or other health service administration or their equivalent as approved by the Commissioner.

"3.05. Director of Nursing Service

"A registered professional nurse, who shall be known as the director of nursing shall be in charge of the nursing and personal care of all patients. Such nurse shall have appropriate training or experience in nursing administration satisfactory to the Commissioner.

"3.06. Dietitian or Nutritionist

"In all homes, the dietary service shall be under the regular supervision of a qualified dietitian or nutritionist whose training and experience shall be acceptable to the Commissioner.

"3.07. Social Worker

"The social workers required by this code shall provide casework service or access to casework service to patients and their families requiring help in the resolution of their personal and social problems; participate in developing and carrying out the treatment program for each patient; assist patients to make a satisfactory adjustment to group living; enlist the cooperation of community agencies in rendering needed services to patients. The home shall make it possible for the patient to consult with the social worker in privacy.

"3.08. Recreation Leader

"The recreation program in all homes shall be under the regular supervision of a recreation leader whose training and experience shall be approved by the Commissioner.

"3.09. Personnel Policies

"Every home shall have personnel policies which shall be provided in writing to all employees. These policies shall specify or otherwise indicate the provisions which govern the condition of employment.

"4.02. Admission and Transfer Policies

"The Commissioner shall have the right to determine the suitability of the placement of patients in homes and the need for their relocation. This relocation shall be accomplished in consultation with the patients, the nearest of kin or sponsors and the patients' physicians. (This code defines categories of patients and age groups who may or may not be admitted.)

"Patients requiring diagnostic study, medical care or treatment of a level that cannot be performed in the home shall be transferred to a hospital or other appropriate health care facility. Such transfers shall be effected in consultation with the patient, his nearest of kin or sponsor and the patient's physician.

"The patient, the nearest of kin or sponsor shall agree as part of the admission agreement to a physician visit at least once every thirty (30) days and more often when medically indicated.

"4.03. Location of Handicapped Patients

"Legally blind and non-ambulatory patients shall not be housed above the street level floor unless the building is of fire-proof class I construction and equipped with elevators and means of egress as provided for in this code and as approved by the Commissioner.

"4.05. Personal Life and Welfare of Patients

"The dignity and individuality of the patient shall be respected at all times. The home shall assist patients to maintain contact with family and friends. It shall permit each patient as much freedom of choice and opportunity to participate in activities in the community or in the home as is consistent with his safety and capabilities.

"Patients shall be permitted as much personal freedom as their physical condition and the orderly management

of the home permit. Patients, able to do so, shall be permitted to come and go at reasonable hours.

"Provision shall be made for maximum ambulation commensurate with the patient's condition.

"Visiting hours shall be prominently posted. As a minimum, visiting shall be permitted six (6) days a week from twelve (12) noon to eight (8) p.m.

"The home shall provide individual and group activities suited to the patients' needs and interests. These activities shall be supervised by a recreation leader. Each home shall have suitable recreational areas as defined in this code, and patients shall have free access to these areas.

"Patients' spiritual needs shall be provided for as requested. Members of the clergy shall be permitted to see patients at all reasonable hours.

"Patients shall not be locked in their rooms at any time.

"4.08. Telephone Service

"There shall be at least one operational, unlocked non-coin telephone installation on each floor of the home. In addition, there shall be coin operated telephones accessible to all non-bedfast patients.

"4.10. Notice of Rate Schedule

"Every home shall exhibit to all persons applying for admission a complete statement enumerating in detail all charges, expenses and other assessments, if any, for services, materials, equipment and food, which shall or may be furnished or supplied to such patients during the period of residency. Such statement as herein provided shall be annexed to the application for admission provided by the home. No additional charges or expenses may be assessed against such patients in excess of that contained in such statement, except under certain defined situations.

"5.01. Filing and Accessibility of Records

"All homes shall keep complete and accurate records in a manner approved by the Commissioner.

"The licensee shall be responsible for the maintenance of all records which the home is required to keep.

"Information contained in patients' medical records is privileged and confidential. Disclosure of such information to unauthorized persons without the consent of patients or their sponsors is prohibited.

"A Medical Record shall be kept for each patient. (The Code goes into considerable detail as to contents of the Record.)

"6.01. Designation of a Personal Physician

"Each patient, at the time of admission to a home, shall designate a personal physician and alternate, or have a physician and an alternate plan for coverage designated by the sponsor or individual responsible for the patient. Medical care shall be provided by the patient's personal physician or the physician assigned by the sponsor or individual responsible for the patient. It shall be the responsibility of the administrator to see that the patient receives such care as and when prescribed by the patient's physician. It shall be the responsibility of the administrator or his designee to see that a physician is promptly called at all times when a physician's services are required.

"All physicians, dentists and podiatrists who treat patients in homes shall hold a current license to practice in the State of New York.

"6.03. Admission Medical History and Examination

"(a) Every patient admitted to a home shall undergo a complete physical examination by a physician within twenty-four (24) hours of admission unless he has had such an examination by his personal physician within five (5) days prior to his admission.

"(b) The admission history shall contain a report of a chest x-ray taken

within ninety (90) days prior to the patient's admission to a home.

"(c) Every patient shall receive, within fourteen (14) days prior to or following his admission, a blood examination consisting of a hemoglobin or hematocrit and a white cell count. If indicated, a white cell differential shall be done. Every patient shall receive within fourteen (14) days prior to or following his admission, a complete urinalysis. Every patient shall routinely receive such a blood examination and urinalysis once a year and more frequently, if indicated. The Administrator shall see that the results of the chest x-ray, of the blood examination and of the urinalysis are entered in the patient's medical record.

"(d) There shall be a yearly review of each patient's dental and ophthalmological status with an appropriate entry made thereof in the medical record.

"An assessment of each patient's condition shall be made at the time of admission or within thirty (30) days after admission. This assessment shall be the basis for a comprehensive treatment and discharge program which shall be developed in writing for each patient. The administrator shall be responsible for seeing that this program is developed; that it is recorded in the patient's chart; implemented; and reevaluated at least once every six (6) months.

"6.06. Medications and Treatments

"(a) No medication or treatment shall be given except on the written and signed order of a physician, dentist or podiatrist, except that in an emergency telephone orders may be accepted and acted upon by the licensed nurse in charge.

"6.12. Diagnostic Services

"Clinical laboratory services other than those tests which can be properly performed in the home shall be expeditiously provided at the request of the patients' physicians by duly licensed laboratories. X-ray services shall be provided at the request of the patients' physicians.

"6.13. Physical Therapy

"The administrator shall make arrangements to provide patients with physical therapy on the prescription of the patients' physicians. The physician shall prescribe what treatments and exercises are to be carried out by licensed physical therapists.

"6.14. Podiatry Service

"The administrator shall make arrangements to provide patients with podiatry service at the request of the patient, the patient's nearest of kin or sponsor, physician or nurse.

"Following each visit the podiatrist shall enter a progress note in the patient's medical chart.

NURSING SERVICE

"Introductory Notes

"Skilled nursing care includes those procedures employed in caring for the sick which require some technical nursing skill beyond that which the ordinary untrained person can adequately administer. These may include full bed baths, enemas, irrigations, catheterizations, application of dressings or bandages, administration of medications by whatever method the physician orders (oral, rectal, hypodermic, intra-muscular), and other treatments prescribed by the physician.

"The personnel of a home shall cooperate with physicians in programs designed to reduce or prevent incontinence and reduce bedfastness by encouraging activity, ambulation, self help and maintenance of range of motion to prevent or reduce physical disabilities.

"7.01. Provision of Nursing Care

"The nursing service shall, at all times, provide for every patient such skilled nursing care and supervision as will protect his physical and emotional well being.

"Such nursing care shall be carried

out consistent with the treatment program developed for each patient following admission but shall be adaptable to changes in the patient's condition.

"Proper nursing care includes but is not limited to periodic observation of each patient by members of the nursing staff throughout the day and night; visiting, at least once an hour, bedfast patients who are unable or unwilling to use the nurses' call system; recording of pertinent observations in the nurses' notes at least once during each nursing shift; accompanying physicians when they visit their patients. (The Code goes into criteria for Nursing Care in detail.)

"7.03. Required Nursing Personnel

"Every home shall have sufficient nursing personnel, including at least one licensed nurse on duty and working in the home at all times, to assure complete, safe and efficient nursing care for all of its patients. Such personnel shall be available at all times to respond promptly to patients' needs and requests. The nursing personnel shall not be assigned duties other than those associated with giving care to patients.

"The following nursing personnel shall be the minimum who shall be on duty daily:

"(a) At least two (2) registered nurses for the first sixty (60) beds, or part thereof, and one (1) additional registered nurse thereafter for every sixty (60) beds or part thereof which the home is maintaining as its bed complement. The registered nurses required herein shall be assigned to one (1) eight (8) hour tour of duty during each twenty-four (24) hour period.

"(b) The registered nurses required herein shall be assigned so that at least one (1) registered nurse shall be on duty during the morning tour of duty and one (1) registered nurse shall be on duty during the night tour of duty. When more than two (2) registered nurses are employed, at least one (1) registered nurse shall be assigned to the afternoon tour of duty.

"(c) The director of nursing service shall not be included in this minimum staffing pattern in homes having more than one-hundred-twenty (120) beds.

"(d) In addition, practical nurses shall be employed in a ratio of one (1) to every twenty (20) beds or part thereof which the home is maintaining as its bed complement. In no event shall the home have less than two (2) practical nurses unless it provides facilities for less than ten (10) patients in which case it shall provide at least one (1) practical nurse in addition to the requirements set forth in paragraph (a).

"(e) The home shall provide at least one (1) attendant for every five (5) beds, or part thereof which the home is maintaining as its bed complement.

DIETARY SERVICE

"8.01. General Requirements

"All food service personnel shall have clean hands and fingernails; they shall wear clean washable outer garments; be free from communicable diseases and open infected wounds. They shall observe all food handling requirements of the Department of Health.

"The home shall provide its patients with well-planned, attractive and satisfying meals which shall meet the patients' nutritional needs.

"The home shall encourage the regular use at meal time of the dining room facilities by all patients who can come or be assisted to the dining room. These dining room facilities shall be separate and apart from the dining room facilities for the home's personnel, except as otherwise provided in this code.

"8.03. Diet

"Patients' food and nutrient needs shall be met in accordance with the current Recommended Dietary Allowances of the Food and Nutrition Board

of the National Research Council adjusted for age, sex and activity. (The Code gives considerable detail as to diet, preparation and patient assistance.)

"10.12. Communications System

"(a) An electrical call system, approved by the Commissioner shall be provided at each patient's bed. This system shall register above the door to the room where the call originates and at the nurses' stations, utility rooms and floor pantries.

"10.13. Sprinklers and Fire Alarms

"(a) All new construction shall be protected throughout with an approved automatic wet-pipe sprinkler system equipped with approved sprinkler alarms connected directly to Fire Headquarters through an approved Central Station.

"(b) Existing Homes

(1) All existing homes in other than Class I construction shall be protected throughout with an approved automatic wet-pipe sprinkler system equipped with approved sprinkler alarms connected directly to Fire Headquarters through an approved Central Station.
(2) All existing homes in Class I construction shall be inspected by the Fire Department which will make appropriate recommendations to the Commissioner.

"(c) Every home shall be protected throughout with an approved local electric interior fire alarm system, installed in accordance with the Administrative Code and Interior Fire Alarm Rules of the Board of Standards and Appeals.

"(d) Every home shall provide a watchman or a watchman service satisfactory to the Fire Department who shall visit all portions of the premises at regular and frequent intervals and an approved system of time detectors to properly record the movements of the watchman.

"(e) The installation and types of all sprinkler and fire alarm systems shall be approved by the Department of Buildings and the Fire Department.

"2.08. Revocation or Non-Renewal of a License

"The Commissioner may revoke a license after a hearing and determination thereon.

"(a) Grounds for revocation or non-renewal:

(1) Failure to comply with federal, state and municipal laws, ordinances, standards, sanitary codes, and other codes, rules and regulations and orders applicable to nursing homes.
(2) Conduct of a home in a manner deemed by the Commissioner to be detrimental to the health, safety or welfare of patients or employees.
(3) The commission of immoral or illegal acts in the home.
(4) Misrepresentation of a material fact by the licensee or his authorized representative.

"1.04. Modifications and Exceptions

"(a) Notwithstanding any other provision contained in this code, where there are practical difficulties or unnecessary hardships in existing homes in complying with the strict letter of the provision of this code, the Board shall have the power in a specific case to modify any provisions thereof in harmony with the general purposes and intent of this code. Any such modification granted to any home shall be effective for the period specified therein, or if no period is specified, such modification shall be permanent.

"(b) The Commissioner shall license all existing homes which comply structurally with the minimal standards established by the Board in the "guidelines" which were adopted by it and became effective May 24, 1961, following the repeal of the "grandfather clauses" of the Hospital Code provided that such homes comply with the other requirements applicable thereto.

"The Board may establish additional guidelines as a basis for application of this code to existing homes which do not comply structurally with the provisions of this code."

More important than words on paper is what is done about them. The department has tried to be progressive, reasonable but firm, based on policies and guidelines adopted by the Board of Hospitals. "Guidelines" represent those deviations from the new code which the board will permit permanently or temporarily. These grew out of the fact that no "grandfather" clauses were built into the new code—quite in contrast to the total abdication to the status quo which has occurred in some jurisdictions. It is the view of the board that physical facilities must meet at least minimal standards and that in fairness to owners who have to make alterations enough time must be allowed to do so.

Each nursing home is being subjected to a total appraisal.* The licensee(s) is then advised at the staff level of the department as to the overall package of improvements which must be brought about and on what time schedule. If the licensee differs he is entitled to a hearing before the code committee of the Board of Hospitals, who is turn recommend to the full board. As a result of this process, about 30 nursing homes went out of business or converted to unsupervised hotels for senior citizens (they have since been brought under the State Department of Social Welfare). The remaining 87 are by and large doing or trying to do a good job and are receiving the full cooperation of the department.

To assist them, approved training courses for administrators have been given by Columbia University's School of Public Health and Administrative Medicine through its Program of Continuation Education. Live television training programs for aides and attendants have been put on UHF through the city's broadcasting system. Nurse faculty members of the department worked with nursing directors and supervisors in each home. Training films are being produced. Two training centers have been contracted for under university auspices. A demonstration social service project is underway to develop standards.

The Department of Health in handling the Department of Welfare's medical care responsibilities has contracted for a variety of mechanisms to improve medical care largely replacing an ill-reputed panel physician system. New municipal nursing home beds are being planned adjacent to municipal or voluntary hospitals to facilitate good care. And finally, in spite of higher standards which mean higher costs, hundreds of new proprietary beds are being built. A new state loan program (100 per cent) to voluntary agencies is before the state legislature.

Regardless of one's philosophy about the profit motive in the health facilities field, as far as our elderly citizens are concerned proprietary facilities are here to stay. Government's obligation then is to insist on high standards and to assist in their achievement. There will always be those who will cut corners to maximize a profit and for such institutions there is no substitute for firm surveillance. In New York City, for example, if a proprietary nursing home is given a "restricted license" prohibiting the admission of new patients, the Department of Welfare drastically reduces the monthly rate of payment, and if there are no improvements—removes welfare patients.

The problem of standards facing the nation is enormous, but the Social Security Amendments of 1965 bind the secretary of health, education, and welfare to locally enacted standards which are higher than those which he may promulgate. The medicare standards for

* For details of code implementation, the reader should contact Commissioner Alonzo Yerby or Assistant Commissioner Jacob Horowitz, Department of Hospitals, 125 Worth Street, New York City.

"extended care facilities" are very well done but limited by the need for national applicability. Hence, there is no excuse for any delay in any state or political subdivision thereof, which has the resources and strength with which to move ahead. Voluntary accreditation is a hopeful step forward, but, as always, is minimal and should not be used as an excuse for not doing what needs doing—where and when it can.*

* See also Conditions and Problems in the Nation's Nursing Homes, Hearings before the subcommittee on Long-Term Care of the Special Committee on Aging of the United States Senate. Part 5. New York, N. Y., August 2 and 3, 1965. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

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Chemical and Biological Defense Training

A chemical and biological defense training course, sponsored by the U. S. Public Health Service, Division of Health Mobilization, has been scheduled for October 10-14, 1966; February 27-March 3, and May 22-26, 1967. The five-day sessions will be conducted in cooperation with the U. S. Army Chemical Center and School at Fort McClellan, Ala.

The course is designed to train public health and medical personnel in the development of chemical and biological defense programs within states, counties, and principal municipalities. Personnel of government agencies at these levels and of other agencies concerned with civilian health are eligible. Security clearance is not required and there is no tuition fee.

Students will be instructed in the development of chemical and biological defense planning and training as well as in the development of postattack programs. The following subjects will be covered: public health aspects of chemical and biological warfare; detection, identification and current capabilities of chemical and biological agents; defensive technics and the care and use of defensive equipment; survey and delineation of contaminated areas and decontamination technics; first aid and other treatment of casualties; and the psychological aspects of chemical and biological weapons.

This course will be of particular value to representatives of health departments, faculty members of schools affiliated with the Medical Education for National Defense Program, and representatives of Veterans Administration and Public Health Service.

Enrollment forms are available from Dr. W. Fulton Abercrombie, Training Branch, Division of Health Mobilization, Public Health Service, Washington, D. C. 20201.